How Welfare Professions Contribute to the Making of Welfare Governance

Professional Agency and Institutional Work in Elder Care

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How welfare professions contribute to the making of welfare governance: professional agency and institutional work in elder care

Abstract

Welfare governance in elder care has undergone significant changes, but we know less about the processes and actors of making welfare governance. This is problematic, as the concern for process is a key strength of the welfare governance perspective. Based on a case study of elder care in Denmark, and drawing on studies of professions, the aim is to analyse how welfare professions contribute to the making of welfare governance. Our analysis shows that welfare professions bring unique resources into play. They have strong professional agency, drawing on both broader institutional roles and more specific professional projects. The institutional work itself is highly complex and the welfare professions combine not only formal and informal coordination, but also do so in ways that are closely tailored to specific contexts. The analysis makes important empirical and theoretical contributions to the study of welfare governance in elder care.

Keywords: Welfare professions, welfare governance, professional agency, institutional work, elder care

Introduction

The welfare governance in elder care has undergone significant changes in recent decades. Welfare governance captures different ways of coordinating welfare activities in complex and fragmented societies (Daly, 2003; Jessop, 1999; Newman 2001). In elder care, changes have drawn on both, New Public Management (NPM) and New Public Governance (NPG) (Torfing *et al.*, 2020). This has included: on the one hand quasi markets in form of purchaser-provider splits, performance management through documentation and quality standards as well as the strengthening of users with measures such as personal budgets; and on the other hand, collaboration through care pathways and integrated teams as well as co-production with volunteers (Szebehely and Meagher, 2014; Moberg, 2017; Newman, Glendinng and Hughes, 2008; Lewis and West, 2014).

The existing literature on welfare governance in elder care has tended to be concerned with mapping out governance arrangements and their effects on organising elder care services (for example Burau, Theobald and Blank, 2007; Hayes and Moore, 2017; Moberg, Blomqvist and Winblad, 2018; Ranci and Pavolini, 2012). However, we know less about the processes and actors of making welfare governance. This is problematic, as the concern for process is one of the key strengths of the welfare governance perspective (Daly, 2003), reflecting a greater interest in the subnational levels of governing and in policy implementation understood as the practice of delivery (Jessop, 1999). The introduction of more collaborative forms of welfare governance over the past decade, such as cross-sector partnerships and personalisation (Fleming and Osborne, 2019) further underlines the importance of process and actors. Welfare organisations are emerging as central sites for welfare governance (Dickinson, 2014). They are typically highly professionalised service organisations and therefore, welfare professions are likely to be key actors in the making of welfare governance (Dahl, Eskelinen and Boll Hansen, 2015; Daly, 2003; Järvinen and Mik-Meyer, 2012).

Based on a qualitative case study of elder care in Denmark, the aim of the present paper is to analyse how welfare professions like nurses, physiotherapists, occupational therapists and care assistants contribute to the making of welfare governance in elder care through their professional practices. Theoretically, we draw on studies of professions, and we use the concepts of professional agency and institutional work to account for the underlying rationales and the formal/informal practices that constitute welfare professions' contribution to the making of welfare governance in elder care (Doessing, 2018a; Strandaas, Wackerhausen and Bondas, 2019). The case study concerns the introduction of a Care Pathway, which draws on elements from different governance paradigms. The Care Pathway standardises care into different packages, each with clearly defined milestones and a corresponding division of labour. The Care Pathway also focuses on improving collaboration between different professions and parts of the organisation. The former draws on NPM, whereas the latter is inspired by NPG. The combination of the two offers a strong test of the contribution of welfare professions to welfare governance. Our analysis shows that welfare professions bring unique resources into play. In terms of professional agency, they have strong rationales for engaging in the governance of elder care, drawing on both broader institutional roles and more specific professional projects. The institutional work itself is highly complex and the welfare professions combine not only formal and informal coordination, but also do so in ways that are closely tailored to specific contexts.

The next section outlines the theoretical framework of our analysis. The subsequent section accounts for the methods of our study, and the following section presents the results of the analysis. We conclude by summarising our findings and discussing our contribution to the literature.

Theoretical understanding how welfare professions contribute to the making of welfare governance

Some of the literature on welfare governance acknowledges indirectly the importance of welfare professions. Jessop (1999), for example, identifies the practice of delivery as one of three dimensions of governing welfare activities. Other parts of the literature recognise welfare professions more directly. For example, Newman (2001) stresses the continued influence of welfare professions in contemporary welfare governance, also as subjects of new forms of governing. Similarly, Daly (2003) suggests that the roles and behaviour of welfare professions are important for understanding how welfare reform proceeds and why. However, the literature does not offer any more specific conceptualisation of how welfare professions contribute to the making of welfare governance. For the literature on street-level bureaucrats, this is a question of implementation driven by individual front-line practitioners (Lipsky, 1980; Hjörne *et al.,* 2010). In elder care, nurses, care assistants and home helpers and occupational and physiotherapists are responsible for translating public service programs into daily practice at the front line. In the process, street-level bureaucrats exert considerable influence on the specific services delivered and on the lives of the users covered by individual programmes (Hjörne *et al.,* 2010). However, with its focus on individual front-line practitioners and processes of implementation, the literature does not fully acknowledge how welfare professions are part of broader welfare governance efforts in welfare states that historically built on 'professional (welfare) bureaucracies' (Burau, 2016; Clarke, Newman and Smith, 2007).

Studies of professions allow doing this by conceptualising welfare professions as collective actors. Welfare professions emerge as mediators between the state and its elder citizens, they administer the welfare right to elder care on behalf of the state, and they materialise these

welfare rights for individual elder citizens by delivering elder care services (Bertilsson, 1990; Burau, 2016; Kuhlmann, 2006). Specialised knowledge and corresponding credentials give welfare professions additional legitimacy. Recent contributions to studies of professions draw on institutionalist theory and focus on the meso level of organisations (for an overview see Ackroyd, 2016; Denis, van Gestel and Lepage, 2016; Muzio and Kirkpatrick, 2011; Muzio, Brock and Suddaby, 2013). This helps conceptualising the activities of welfare professions in welfare organisations as the main arenas for welfare governance. Studies build on a view of organisations as interrelated systems of professions. In elder care, a classic example is the division of labour between health care and social care. It is shaped by both the expert knowledge and interests of different welfare professions like nurses, physio- and occupational therapists, and by the rationales of managers of nursing homes and home care providers. Welfare professions are important actors in processes of institutional change. They construct and organise elder care services in different ways, using a complex set of practices to help secure managerially defined goals, for example those concerned with service delivery in inter-professional teams. However, such processes also offer welfare professions a lever for professional development such as working in ways that better respond to user needs.

What makes welfare professions contribute to welfare governance in elder care as part of their daily work in nursing homes and in home care? Studies of professions have long considered professional interests in increasing autonomy and influence over other professional groups as the core of professional agency (for an overview see Ackroyd, 2016). However, this is changing, and now knowledge and related credentials have to match organisational functions and market forces (Brint, 1994). Importantly, this is a salient feature of welfare professions, including in elder care, which have tended to develop in tandem with welfare states. Muzio and colleagues (2013: 706) make a case for a broader understanding of professional agency. From this perspective, professions

play more diverse institutional roles: providing categories to frame issues such as the good life in old age (cultural-cognitive dimension), offering norms to guide action, for example what it means to be a competent care worker (normative dimension), and engaging with legally sanctionable rules like standards for documenting care (regulative dimension).

What are the concrete practices that constitute welfare professions' contribution to the making of welfare governance in elder care? Building on arguments about the growing importance of organisations as central sites of (welfare) governance, several authors stress the need to focus on the daily practice of professional work (Denis *et al.,* 2016; Muzio *et al.,* 2013). The concept of 'institutional work' captures exactly the mundane and everyday activities, designed to create, change and maintain institutions. Such activities involve reflexivity (Muzio *et al.,* 2013: 708; also Breit, Andreassen and Salomon, 2016): welfare professions consider how their actions relate to specific contexts, for example whether a home care provider is located in an urban or a rural setting, and they are able to vary routine action accordingly. Importantly, this can include both acts of contributing to and resisting change.

For welfare professions, institutional work is often concerned with working at the switchboards of welfare states, coordinating services within and across different organisations (Allen, 2014; Doessing, 2018b). This includes both formal and informal practices of coordinating elder care across a range of organisational and professional boundaries. Formal coordination is typically tied to macro- and meso-level structures of elder care service organisation. However, formal coordination is intertwined with informal coordination, which can be both supplementary and by-passing and include informal meetings and non-obligatory telephone calls and e-mails (Doessing, 2018a). The interplay between formal and informal coordination thus goes to the heart of how welfare professions contribute to the making of welfare governance in elder care. Firstly, they employ professional agency that rests on both professional and organisational rationales

(Muzio *et al.,* 2013). Secondly, they engage in inter-organisational coordination as institutional work that draws its strength from reflexivity, understood as the ability to relate and adjust actions to specific contexts (Doessing, 2018a: 700).

Methods and data

The analysis was based on a qualitative case study of the introduction of an inter-professional Care Pathway in elder care in the municipality of Aarhus in Denmark. We used a multiple case design (Yin, 2017) to better understand the complex ways in which welfare professions address dilemmas in welfare governance through institutional work.

Study setting

The municipality of Aarhus introduced the 'Care Pathway' in March 2016. The Care Pathway is an example of a widespread trend in elder care to standardise everyday rehabilitation in nursing homes and home care services and to strengthen inter-professional coordination in elder care (Petersen *et al.,* 2017; Moe and Brataas, 2016). This is part of broader policy developments, which have a strong focus on facilitating the hospital discharge of elder people and preventing hospital admissions (Madsen et al., 2020). In the context of Denmark, the main professional groups employed in elder care are nurses, care assistants and home helpers (two-years training) as well as physio- and occupational therapists. Social workers may be involved, but this occurs rarely. Like other welfare states, Denmark has marketised elder care and introduced ‘free choice’ of provider (2003). Nevertheless, municipalities continue to run the great majority of nursing homes and home care services, and this also applies to Aarhus and the specific providers included in the study.

The Care Pathway contains three main elements (Sundhed og Omsorg, 2018). *First*, all citizens receiving elder care are assigned to one of three care path types (a simple care path, a combined care path or a permanent care path). *Second*, citizens in all care paths are assigned a contact person and a care coordinator with joint responsibility for the individual care path. The former is the main care provider and the latter is in charge of coordinating the citizen's different care and rehabilitation services. *Third,* all care paths have the same basic structure, centred on regular case conferences.

The municipality of Aarhus has approximately 340,000 citizens, which makes it the second largest municipality in Denmark. The provision of elder care is organised in different districts that differ with respect to geographical size and proximity among care providers. Within each district, there are two types of providers: nursing homes and home care providers. The latter include one health care unit and 4-6 home care units. The units differ in terms of the professional groups; while the health care units primarily include nurses, physiotherapists and occupational therapists, the main professional groups in the home care units are care assistants and home helpers.

Case selection

We included two out of the seven geographical districts delivering elder care in the municipality of Aarhus (District Lakeshore and District Hilltop). Case selection aimed to maximise variation of the context of coordination. The literature suggests that geographical proximity is an important factor influencing coordination across organisations and professions. Short geographical distances facilitate face-to-face interactions and therefore foster coordination, whereas the opposite is true for longer geographical distances (Knoben and Oerlemans, 2006; Madsen and Burau, 2020). We chose geographical size of districts as a proxy for geographical proximity and thus included one smaller and one larger district. Within each district, we included different provider organisations (the health

care unit, one home care unit and two nursing homes) to maximise variation in the organisational settings.

Data collection

Data was collected based on a combination of observations and qualitative interviews in spring 2018. Observations included non-participant observations of eight full working days of different professional groups in different provider organisations and eight case conferences. This provided insights into inter-professional interactions as they unfolded in practice, as well as the underlying tacit knowledge (Hammersley and Atkinson, 2007). The field notes consisted of both descriptive information (factual data) and reflective information (thoughts, ideas, questions, and concerns) (Hammersley and Atkinson, 2007).

We conducted focus group interviews (Carey and Asbury, 2012) with staff in each type of provider organisation in the two districts (six interviews). Selection of informants included representatives of all professional groups, including nurses, occupational therapists, physiotherapists, care assistants and care helpers (see Table 1 for an overview). We also conducted individual semi-structured interviews (Brinkman and Kvale, 2015) with managers of the provider organisations in each district (six interviews) and with the overall management of each district (two interviews). The interviews lasted approximately 30-60 minutes and were based on an interview guide concerning issues related to professional agency, institutional work and organisational contexts (Brinkmann and Kvale, 2015). We digitally recorded, transcribed verbatim and anonymised all interviews.

[TABLE 1 ABOUT HERE]

Data analyses

The analysis began by constructing and applying a set of codes derived from the operationalisation of the central theoretical concepts and sub-concepts of our theoretical framework. All authors independently performed preliminary test-coding of selected interviews and field notes of observations. This was discussed by the authors to refine the codes and settle any differences in coding practice. All interviews and field notes were then coded. Subsequently, the coded material was analysed based on a thematic approach (Braun and Clarke, 2006). The material was discussed among all authors and collated to create preliminary themes, which were subsequently reviewed and refined. The themes were investigated in relation to the full data set looking for disconfirming evidence and in relation to the operationalisation of our theoretical framework (Maxwell, 2013).

Ethical approval

According to Danish legislation, this type of study does not require approval from the Committee on Health Research Ethics (see Act on Research Ethics Review of Health Research Projects, Law no. 593, 14 June 2011; https://www.nvk.dk/english/act-on-research). All participants were thoroughly informed about the study and written consent was obtained prior to data collection. Furthermore, participants could edit the transcript of the interview. Direct or indirect references to the individual provider organisations and individual participants were subsequently removed. All participants approved the final written and anonymised transcripts.

Welfare professions and the making of governance in elder care

Professional agency – between broader institutional roles and more specific professional projects

Across districts and provider organisations, professional agency rested on a powerful combination of broader institutional roles and more specific professional projects. Professionals referred to broader, cultural-cognitive institutional roles (Muzio *et al*., 2013) when they accounted for what made them engage in defining, developing and maintaining the Care Pathway. This concerned different ways they used the Care Pathway as a frame to formulate how inter-professional coordination was meaningful, and, based on this, to outline shared understandings and scripts for action. One dimension of this type of professional agency centred on increased possibilities of ensuring continuity in individual Care Pathways. Professionals saw the Care Pathway as an opportunity to clarify further the transitions between different professional groups and different provider organisations. They connected this to perceived benefits for elder persons.

> *'As care coordinators, we also get to know the individual elder person much better.* […] *This also offers elder persons additional reassurance, as they know the particular professionals who come to them. The same is true for the elder person's family.'* (Care assistant, nursing home, Lakeshore)

Another dimension of this type of professional agency was related to making the most of better opportunities for inter-professional working, within and across provider organisations. Working within the Care Pathway offered a springboard for developing a joint understanding of the individual elder person. Case conferences were an important lever for doing this.

> *'As a care assistant, I am all ears when we have case conferences. This is because we each have our specific perspectives as physiotherapists, occupational therapists, care*

assistants and helpers. […] *The Care Pathway helps us to develop a joint perspective.'*

(Care assistant, nursing home, Hilltop)

With the formal nature of the case conferences, professionals developed skills for spotting any new challenges individual elder persons were facing and for adopting a more holistic perspective of the individuals concerned. Professionals connected this to seeing the Care Pathway as a means to accelerate and standardise their professional practice, for example through drawing up a care plan and using the common language offered by the Care Pathway.

Importantly, professionals combined agency based on broader institutional roles with agency based on more self-interested professional projects. This became particularly apparent when professionals described the challenges they faced working with the Care Pathway in the context of tight personnel and time resources. In response to greater demands for coordination and documentation, professionals articulated more specific professional rationales. Across professional groups, this centred on working with the elder person as the core of their professional practice. For example, an occupational therapist felt that being care coordinator was first and foremost administrative work, which did not make any difference to her professional practice. Similarly, a nurse referred to coordination work as a 'time bandit' and as essentially 'administrative'. From this, the professional project emerged primarily as mono-professional. The professional project was also connected to autonomy, and several professionals criticised the Care Pathways for sometimes making professional practice less flexible. For example, professionals could be slow in taking action as the Care Pathway rather than the specific situation at hand became the primary focus.

Professionals further fleshed out the more self-interested professional projects when they accounted for the contribution of their individual professional groups to the Care Pathway. Overall, the individual contributions seemed to be part of a hierarchical division of labour, with

nurses at the top, physio- and occupational therapists and partly care assistants in the middle and home helpers at the bottom. This particularly applied to nursing homes, where nurses long had had a coordinating role. In home care units, nurses and physio- and occupational therapists primarily had the role of consultants, whereas in the health care units they delivered hands-on specialist care and rehabilitation.

Across provider organisations, nurses stressed that they contributed a health professional perspective, including wound care, care plans, contact with general practitioners and coordination of different tests, as well as supervision of other professionals. The specific contribution of nurses varied to some degree between provider organisations. In nursing homes, nurses delivered both care and supervision, while this was more clearly separated in home care services.

> *'The job descriptions we received as part of the introduction of the Care Pathway stated that we should support care assistants and helpers, particularly in connection with their new roles as contact person and care coordinator.'* (Nurse, home care unit, Hilltop)

Therapists generally argued that their contribution lay in assessing the elder persons, guiding other professionals and conducting therapeutic training with the elder person. As such, therapists often had more of a supporting role, especially vis-à-vis care assistants and home helpers, also to ensure the continuity of care paths.

> *'I accompany care assistants when they visit the elder person […]. I ask the necessary questions, which help the care assistant to come up with relevant solutions to the*

problems that present themselves. This is where I draw on my specific professional knowledge.' (Occupational therapist, home care unit, Hilltop)

As with nurses, the specific contribution of therapists varied between provider organisations. In home care units and health care units, the supervision and care delivery were separated, whereas the two were often more integrated in nursing homes.

Across provider organisations, the contribution of care assistants had a hybrid quality that was located in between nurses and home helpers. The Care Pathway had given care assistants and helpers new roles as care coordinators and contact persons respectively, and this seemed to sharpen their awareness of self-interested professional rationales.

'We are both a kind of helper who can do a little more and a 'mini-nurse' who can do basic wound care. […] This is what I call overview. […] Not all professional groups have the same close attention to detail as care assistants have.' (Care assistant, nursing home, Lakeshore)

Day-to-day observations were another important contribution of care assistants and home helpers. This particularly applied to home helpers, as assistants often had to juggle different responsibilities, which included being care coordinators for several elder persons at any one time.

In summary, our analysis shows that welfare professions have powerful rationales for engaging as institutional agents in the governance of elder care, as reflected in the diversity of rationales. Nurses, physio- and occupational therapists, care assistants and helpers all referred to clarifying transitions and developing joint understandings/holistic approaches to practice (cultural-cognitive institutional roles). Importantly, these roles co-existed with rationales based on self-interested

professional projects centred on working with the elder person. This combined professional agency offered a solid platform for diverse forms of institutional work, as the following sections show.

Institutional work – practices of formal and informal coordination

Across districts and across nursing homes and home care services, the institutional work of professional groups emerged as a skilful interplay between formal and informal coordination practices that was adapted to particular contexts. This is how professionals translated the Care Pathway into daily practice and coordinated the delivery of elder care within the framework of the Care Pathway. The specific interplay to some degree varied across provider organisations. For example, coordination practices were different depending on whether the service delivery involved a single provider organisation (most often nursing homes) or two providers (most often the health care units and home care units in the home care services).

Practices of formal coordination

Across organisational settings and districts, the formal coordination practices of professionals mainly related to the formal structure and milestones of the Care Pathway and to other platforms for coordination and communication that were already in place in the provider organisations.

The case conferences of the Care Pathway emerged as an important formal coordination platform in both districts. The formal nature of the conferences provided the professionals with a space to create and follow up on care plans, and to discuss and coordinate their on-going care and rehabilitation activities. Moreover, case conferences served as a safety net to ensure that professionals were not missing anything and that any changes in the elder person's

pathway were followed up on. Case conferences were used as a coordination platform in both nursing homes and in home care services. However, they were especially valuable where elder care involved professionals in both health care units and home care units. The conferences offered a space for professionals from different geographical locations to meet face-to-face and to coordinate their rehabilitation and care tasks together with the elder persons and their families.

> *'Case conferences are great. This is where we look each other in the eye and get to talk through individual Care Pathways. All relevant parties are present and we get to talk to real people.'* (Nurse, health care unit, Lakeshore)

Another platform for formal coordination was the electronic documentation system CURA. Professionals used the system to document all information about individual Care Pathways (e.g. rehabilitation plans, care needs and appointed contact person and care coordinator) and to write observations and messages to the other professionals involved (e.g. tasks to perform or points to pay attention to when visiting the elder person). As such, the system enabled professionals to keep up to date with progress on individual Care Pathways and facilitated coordination and communication among professionals. As with case conferences, the system was particularly valuable for Care Pathways that involved both health care units and home care units. The lack of geographical proximity otherwise limited the opportunities for meeting each other and for coordinating face-to-face.

In nursing homes, another important platform for formal coordination was weekly staff meetings. These existed before the introduction of the Care Pathway. Provider organisations in both districts made use of these meetings mainly to assign contact persons and care coordinators to

any new care paths and to discuss ad hoc challenges in existing care paths. There were no corresponding meetings in home care services.

Within organisations, a final platform for formal coordination was whiteboards; they were a repository for information for all current individual pathways, including type of care path, assigned contact person and care coordinator and the date for the next case conference. The professionals used the whiteboards to create an overview of who was responsible for whom; that way, information was readily available when there was an acute need to make contact and to coordinate.

> *'I use the whiteboard to get an overview of how many elder persons we have in the individual types of paths, and how we have distributed tasks among us.'* (Care assistant, home care unit, Hilltop)

In summary, welfare professions made use of various formal coordination practices when translating the Care Pathway into daily practice and coordinating the delivery of elder care. These practices related not only to the structure of the Care Pathway, but also to already existing platforms for communication such as meetings and the documentation system. Institutional work was highly skilful, because welfare professions complemented formal practices with different informal coordination practices.

Practices of informal coordination

Professionals across organisational settings and districts made use of many and different informal coordination practices in addition to formal practices. It is important to note that the two practices were closely intertwined; the ways in which the professionals used informal practices strongly

reflected their ability to vary and adjust routine actions when specific circumstances or contextual factors prescribed it.

One type of informal coordination practice across districts and organisational settings was *supplementary informal coordination*. Professionals used this to support formal coordination practices, especially in connection with the formal milestones of the Care Pathway. Informal practices helped to fill in gaps by supporting the on-going coordination and monitoring of care paths.

Differences in organisational settings to some degree influenced practices of supplementary informal coordination. In nursing homes, supplementary informal coordination was facilitated as professionals shared the same workplace; coordination took the form of ad hoc face-to-face communication and spontaneously organised informal meetings. For example, the nursing homes in both districts frequently used informal meetings before or after the case conference to prepare for or evaluate the conferences.

The organisational setting of the home care providers to some extent limited the opportunities for supplementary informal coordination. The location of home care units and health care units in different geographical locations meant that most supplementary informal coordination took the form of phone calls.

> *'We use a lot of informal coordination. This is about making sure to talk to each other on those days when we are here at the home care unit. We are two days at one unit and two days at the other unit.* […] *And otherwise and depending on how pressing the situation is, we ring each other.'* (Occupational therapist, home care unit, Lakeshore)

Despite different contexts, all professionals made heavy use of supplementary informal coordination practices, as this was a quick and flexible way of keeping each other up to date, asking questions and coordinating activities as and when the need for coordination arose. This was used instead of waiting for the next case conference or for a response to a note written in the documentation system.

> *'Compared to the documentation system, meeting face-to-face or to talking on the phone has many advantages. For example, assistants or helpers in home care services may have small queries but that require quick answers to support them in their daily practice. They can get the answer by dropping by my office. In fact, they do this every single day.'* (Physiotherapist, health care unit, Lakeshore)

Another type of informal coordination practice used across districts and organisational settings was *strategic informal coordination*. Professionals used this practice to manage shortcomings arising from the specific circumstances associated with the use of formal coordination practices. Again, the use of the informal coordination practice varied, but this reflected situational differences rather than systematic contextual differences in organisational settings.

Strategic informal coordination included the use of informal 'shortcuts' related to the formal coordination activities prescribed by the Care Pathway; this was to manage the hectic nature of ordinary working days. For example, a nurse in a nursing home in District Hilltop explained that she coordinated all case conferences in the nursing homes to save time for the individual care coordinators. This was contrary to the guidelines of the Care Pathway, which envisaged this as the responsibility of respective care coordinators.

Care assistant*: 'I am responsible for 5-6 elder persons, but I have not organised any of the care conferences.'*

Nurse: '*This is because I have done that. I feel that you already have lots of things on your plate, so I have organised the care conferences.'* (Nursing home, Hilltop)

This particular informal shortcut built on previous practice with the purpose of optimising time resources. Although these informal shortcuts made changes to the practice of inter-professional coordination as described by the formal guidelines of the Care Pathway, they became the best possible practice in the given circumstances. They also reflected the ability of professionals to vary and adjust their routine actions in the effort to provide the best care for elder persons.

Another example of strategic informal coordination was the use of additional informal coordination activities to supplement coordination through formal platforms; this was either because coordination was insufficient or because of a mistrust in the formal coordination platforms. For instance, in nursing homes, several professionals working day shifts had experienced instances in which evening or night shifts had failed to act on the requests posted on the CURA formal documentation system. In response, professionals on day shifts had started adding informal coordination activities such as keeping a physical diary listing relevant information and tasks, and putting up posters with the relevant practice guidelines in the office and lunch room.

The nurse writes a note for the night shift concerning the medication of one elder person using the formal documentation system CURA. She also writes the note in a paper diary, which lies in the office for everybody to use to give messages to each other. The nurse writes the note twice, as she feels she cannot rely on the night shift reading all messages posted on CURA. (Observation note, nursing home, Lakeshore)

Another example of strategic informal coordination was use of supplementary phone calls, which also reflected a lack of trust in the formal coordination platforms, especially CURA. Among the home care providers, several professionals, particularly from the health units, reported instances of information gone missing or lack of feedback on observations and messages.

> *'In the beginning, I duplicated all messages; for example, I wrote a note in the rota for home visits and I also called my colleagues in home care services. However, I was told my colleagues should be able to keep track of messages themselves, and that it was not my responsibility to follow up. I agree, but I am concerned that information goes missing.'* (Nurse, health care unit, Hilltop)

As evident from the examples, these practices emerged as a strategic, informal way to ensure the necessary and proper coordination in care paths. This reflected the ability of professionals to do more than described in the Care Pathway, to vary and adjust their routine actions in an effort to provide the best care for the elder person. Without the combination informal and formal institutional work, the Care Pathway could not work .

Discussion and conclusion

Welfare governance in elder care has undergone significant changes in recent decades, reflecting successive public management reforms inspired by NPM and NPG. However, we know little about the processes and actors of processes of making welfare governance. This is problematic, as the concern for process is one of the key strengths of the welfare governance perspective. The

introduction of more collaborative forms of welfare governance inspired by NPG over the past decade to address e of the shortcomings of NPM, further underlines the importance of process and actors. Welfare organisations are typically highly professionalised service organisations, and welfare professions are likely to be key actors in the making of welfare governance. Based on a qualitative case study of elder care in Denmark, and drawing on studies of professions, the aim of the present paper was to analyse how welfare professions contribute to the making of welfare governance in elder care through their professional practices. The analysis makes important empirical and theoretical contributions to the study of welfare governance in elder care and highlights the usefulness of the analytical concepts of professional agency and institutional work.

Empirically, the analysis demonstrates the important contribution welfare professions make to welfare governance in elder care and specifies the nature of their contribution (see Table 2 for an overview). Welfare professions have powerful rationales to engage in welfare governance, as they draw on both organisational and professional concerns such as ensuring good, continuous care for vulnerable elder person/elder persons in need of cares. The engagement of welfare professions in welfare governance is highly skilful, as it is an adaptive interplay between formal and informal coordination practices of elder care services.

[TABLE 2 TO FEATURE ABOUT HERE]

In terms of their *professional agency*, welfare professions in the Care Pathway drew on diverse rationales. This included rationales based broader institutional roles, reflecting historically close relations between welfare professions and elder care services (Dahl, 2000; Evertsson, 2000). More specifically, nurses, physio- and occupational therapists, care assistants and home helpers referred to cultural-cognitive institutional roles: they identified increased possibilities

for ensuring continuity of individual Care Pathways, and better opportunities for inter-professional working. Importantly, this co-existed with rationales based on self-interested professional projects; the core of such projects was doing something for and working with the elder person. The welfare professions involved in the Care Pathway also articulated the contributions they saw as distinct to their specific professional group.

The welfare professions involved in the Care Pathway engaged in highly complex forms of *institutional work.* This included formal coordination practices which related to the structure of the Care Pathway and already existing platforms for communication such as meetings and the documentation system. Welfare professions complemented this with informal coordination practices, where the formal milestones of the Care Pathway required further support (supplementary informal coordination) or where shortcomings occurred (strategic informal coordination) (also see Breit *et al.* 2016). Importantly, professional groups fine-tuned the interplay between formal and informal coordination practices to fit specific organisational settings and situations. Variations between organisational settings, and the co-existence of vertical coordination within and horizontal coordination across organisations reflected the high level of adaptation of institutional work.

However, the engagement of welfare professions in the governance of elder care is not without challenges (Denis *et al.,* 2016). It involves additional work, which is often organisational in nature and concerned with making connections across different professional groups and organisations (Allen, 2014; Doessing, 2018a, 2018b). The success of this type of work is far from certain; it requires support by leadership and may also result in resistance on the part of welfare professions (Breit *et al.,* 2016, Denis *et al.,* 2016). Our analysis demonstrates that the institutional work outlined above is concerned with responding to and handling the highly complex demands of welfare governance. The situation is further complicated because the Care Pathway draws on different governance paradigms. The reach of standardised coordination across different professions

and provider organisations is limited by the complex, unpredictable and shifting nature of the needs of elder persons. This forms the backdrop of the institutional work of welfare professions; it is about mediating between conflicting demands and going beyond what is described in the Care Pathway. This was also the finding of a recent study of health care services in the Netherlands (Wallenburg et.al., 2019). Here, welfare professions sometimes even rebelled against formal guidelines in order to secure good care for patients. There are some differences between what 'quality rebels' in the Dutch study and what the welfare professionals in our study did to ensure the smooth delivery of care services. However, both studies emphasise that we need more research on welfare governance and institutional work.

Theoretically, our analysis offers a framework to conceptualise how welfare professions contribute to the making of welfare governance in elder care. Drawing on studies of professions, the concepts of professional agency and institutional work help us to identify the unique resources welfare professions bring into play (similarly, Breit *et al.* 2016). This challenges the widely held view of a more or less strong conflict of interest between public service reforms on the one hand and welfare professions on the other (for example, Mik-Meyer, 2018; Stradaas *et al.,* 2019). Welfare governance emerges as a distributed and pluralistic process, where welfare professions negotiate governing activities in relation to specific contexts (Cloutier *et al*., 2016). Our framework is also relevant for other areas of welfare governance. Wicked problems of coordination are abundant in welfare services and require welfare professions to build bridges across organisations and sectors (Sørensen and Torfing, 2017).

However, professions may be more or less well equipped to contribute to the making of welfare governance. For classical professions like doctors and lawyers, institutional work is often the product of the restructuring of governance arrangements (for an overview see for example Muzio and Kirkpatrick, 2011; Muzio *et al.,* 2013). This is different for welfare professions; they are

intertwined closely with the development of welfare states and for them, institutional work is woven into the very fabric of their professional practice (Allen, 2014; Doessing, 2018a, 2018b). Nevertheless, institutional work demands time and commitment. Feminist scholars suggest the patchwork nature of professional agency and institutional work has a highly gendered character, which is typical of welfare professions dominated by women (Dahl, 2000; Henriksson, Wrede and Burau, 2006). Our study of welfare professions in elder care thus helps to specify Denis and colleagues' (2016) plea to acknowledge the variety of how professions engage in organisational change processes and by extension processes of (welfare) governance at large. More specifically, we need to pay attention to structural differentiations among professional groups in terms of gender. We need to consider how their gendered position in welfare governance shapes the institutional work they do and the conditions for continuing to do so, as well as how it relates to their professional agency.

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Table 1. Overview of participants in focus group interview participants

District	Professional group	Nursing home	Health care unit	Home care provider	Total
Lakeshore	Home helper	1	-	1	2
	Care assistant	1	-	3	4
	Nurse	1	1	-	2
	Physiotherapist	1	1	-	2
	Occupational therapist	1	1	1	3
	Recipient consultant	-	-	-	0
	Dietitian	-	1	-	1
Hilltop	Home helper	-	-	2	2
	Care assistant	1	-	2	3
	Nurse	1	1	1	3
	Physiotherapist	1	1	-	2
	Occupational therapist	1	1	1	3
	Recipient consultant	-	1	-	1
	Dietician	-	1	-	1
	Total	9	9	11	29

Table 2. Overview of professional agency and institutional work in the Care Pathway

Professional agency Rationales for engagement as institutional agents	
Based on broader institutional roles Related to cultural cognitive, normative and regulative dimensions	Especially cultural cognitive institutional roles • Clarifying transitions between professional groups and across provider organisations • Developing joint understanding of elder person and holistic approach to practice
Based on professional projects Related to social closure (maximizing autonomy and dominance over others)	• Core professional practice related to working with elder persons • Some contributions to pathways specific to individual professional groups
Institutional work Practices of formal and informal coordination Includes ability to vary routine action by adapting to specific contexts	• Formal practices relate to structure of the Care Pathway and existing platforms for communication • Informal practices include: - Supplementary coordination (supporting formal structures of Care Pathway) - Strategic coordination (addressing shortcomings) • Interplay between formal/informal practices highly adaptive: - Varies between organisational settings - Includes both vertical coordination within and horizontal coordination across organisations